Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Midland Memorial Hospital

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-15-2978-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Midland Memorial Hospital to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008…"

Amount in Dispute: $223.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 11 -13, 2014	Outpatient Hospital Services	$223.86	$113.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 246 – This non-payable code is required reporting only
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the carrier's reason for denial supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 245 – "This non-payable code is required reporting only". 28 Texas Administrative Code §134.403 (d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section,.." Review of the submitted medical claim finds code 97001 or "Physical therapy evaluation." The carrier states this is a non-payable code. However, this denial is not supported as this code is found to be payable per applicable CMS fee schedule. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Reimbursement for the disputed services is calculated as follows:
   - Procedure code 97530, date of service June 13, 2014, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2014 is $33.45. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of $52.06
   - Procedure code 97001, date of service June 12, 2014, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2014 is $73.00. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of $113.61
3. The total allowable reimbursement for the services in dispute is $165.67. This amount less the amount previously paid by the insurance carrier of $52.06 leaves an amount due to the requestor of $113.61. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $113.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $113.61, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 11, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.